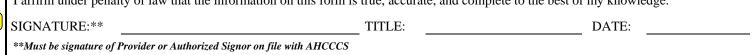


Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

801 East Jefferson, Phoenix AZ 85034 PO Box 25520, Phoenix AZ 85002 phone 602 417 4000 www.ahcccs.state.az.us

Provider Address Update Form

(Completed W-9 Must Be Included)			
NAME (Last, First, M	I.I.): NPI #		
AHCCCS PROVIDER	#: SOCIAL SECURITY #:		
CHECK ONE:	□ ADD ADDITIONAL INFORMATION □ REPLACE EXISTING INFORMATION NOTE: Form will be returned if not completed.		
CORRESPONDENCE ADDRESS			
STREET LINE #1:			
STREET LINE #2:			
CITY:	STATE: ZIP:		
BUSINESS PHONE:	() EMERGENCY PHONE: ()		
ATTENTION TO:			
PAY-TO ADDRESS (SITE 01)			
STREET LINE #1:			
STREET LINE #2:			
CITY:	STATE: ZIP:		
BUSINESS PHONE:	() - EMERGENCY PHONE: ()		
ATTENTION TO:			
	BEGIN DATE: END DATE:		
SERVICE ADDRESS (SITE 01) Must be a Street Address			
STREET LINE #1:			
STREET LINE #2:			
CITY:	STATE: ZIP:		
BUSINESS PHONE:	() - EMERGENCY PHONE: ()		
FAX PHONE:	() - ATTENTION TO:		
	END DATE: PAY-TO LOC. CODE:*		
(*=Please indicate the locator code for the pay-to address that applies to this service address.)			
I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.			



PAY-TO ADDRESS (SITE 02)			
STREET LINE #1:			
	STATE:		
BUSINESS PHONE:	() - EMERGENCY PHONE:	<u>()</u>	
ATTENTION TO:			
EMPLOYER TAX ID#	BEGIN DATE:	END DATE:	
SERVICE ADDRESS (SITE 02) Must be a Street Address			
STREET LINE #1:			
	STATE:		
BUSINESS PHONE:	() EMERGENCY PHONE:		
FAX PHONE:	() - ATTENTION TO:		
BEGIN DATE:	END DATE:	PAY-TO LOC. CODE:*	
(*=Please indicate the loc	ator code for the pay-to address that applies to this service address.)		
PAY-TO ADDRESS (SITE 03)			
STREET LINE #1:			
	STATE:		
BUSINESS PHONE:	() EMERGENCY PHONE:		
ATTENTION TO:			
EMPLOYER TAX ID#	BEGIN DATE:	END DATE:	
SERVICE ADDRESS (SITE 03) Must be a Street Address			
STREET LINE #1:			
STREET LINE #2:			
CITY:	STATE:	ZIP:	
BUSINESS PHONE:	() - EMERGENCY PHONE:	_(
FAX PHONE:	() - ATTENTION TO:		
BEGIN DATE:	END DATE:	PAY-TO LOC. CODE:*	
(*=Please indicate the locator code for the pay-to address that applies to this service address.)			
I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.			



SIGNATURE:**
______TITLE:
______DATE: ______

**Must be signature of Provider or Authorized Signor on file with AHCCCS